

No. 2
4-13-40
5-17-39
PI X23159

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

37285

DEC 22 1941 399
Registration District No.

Primary Registration District No. 1002

State File No.

Registrar's No. 4079

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Joseph Hospital.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 8/24/41 to 11/1/41.
(Specify whether
In this community 4 Yrs.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City Mo.
(If outside city or town limits, write "RURAL")
(d) Street No. 57th & Main St.
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME Catherine HOBBS (Sister St. John)

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month November day 1st
year 1941 hour 8 minutes 35 P. M.

3. (b) If veteran, name war _____ 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased October 1886
(Month) (Day) (Year)

8. AGE: Years 75 Months _____ Days _____ If less than one day hr. _____ min.

9. Birthplace Glenville New York.
(City, town, or county) (State or foreign country)

10. Usual occupation Catholic Nun.

11. Industry or business Sister of St. Joseph.

12. Name Sanders Hobbs.

13. Birthplace Unknown
(City, town, or county) (State or foreign country)

14. Maiden name Margaret McCarthy.

15. Birthplace Ireland.
(City, town, or county) (State or foreign country)

16. (a) Informant Hospital Records.
(b) Address Linwood & Prospect.

17. (a) Burial (b) Date thereof 11/3/41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Marys Cemetery

18. (a) Signature of funeral director Mellody-McGilley.

(b) Address K. C. Mo.

19. (a) 11-2-41 (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Malacia

Due to Cerebral Sclerosis with Occulsion

Due to _____
Other conditions (Include pregnancy within 3 months of death) 83c

Major findings: Of operations _____
Of autopsy _____

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature Dr. John T. Skinner (M. D. or other) _____
Address 1402 1/2 3rd and 16c Date signed 11-2-41

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

..... Registered Apprentice No. *X*

working under my personal supervision.

Signed *J. B. [Signature]*

..... Licensed Embalmer No. *2999*

..... P. O. Address *KC*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.